STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING _____ B. WING _____	02/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 7-11, 2011 Facility number: 003075 Provider number: 155695 AIM number: 200364160 Survey team: Honey Kuhn, RN, TC Mavis Stob, RN Carol Miller, RN Census bed type: SNF/NF: 86 Total: 86 Census payor type: Medicare: 11 Medicaid: 70 Other: 5 Total: 86 Sample: 18 Supplemental sample: 2 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 2/18/11 by Suzanne Williams, RN	F0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post certification review on or after 03/13/2011.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F0157 SS=D	Based on record review and interview, the facility failed to consult with the physician and the resident's Power of Attorney in regard to a resident's refusal of influenza vaccine (Resident #42), failed to consult with the physician in regard to a medication order (Resident #22) and failed to notify the physician in regard to a resident not receiving ordered medications for 3 days (Resident #87). This deficiency affected 3 of 18 residents reviewed for physician's orders in a sample of 18. Findings include: 1. The clinical record of Resident #42 was reviewed on 2/7/11 at 2:10 P.M., and indicated an admission date of 3/5/10, and diagnoses which included but were not limited to dementia and coronary artery disease. A significant change MDS (minimum data set) assessment, dated 12/11/10, indicated the resident had cognitive impairment and had memory problems. Documentation on the immunizations record indicated the resident had refused the influenza vaccine on 1/5/11. There was no documentation to indicate the physician and the family had been notified	F0157	**F 0157What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**It is the practice of this provider to promptly inform the resident, consult with the resident's physician, and notify the resident's legal representative or interested family member when there is a significant change in the resident's physical, mental, or psychosocial status and/or the need to alter treatment significantly.Resident # 42 flu vaccine was given on 11/09/2010.Resident # 22 physician was contacted and informed of medication discrepancy.Resident # 87 has been discharged from the facility.The above mentioned residents experienced no negative outcome as a result of this finding.**How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?**All residents have the potential to be affected by this finding. Newly admitted or readmit residents' medical record will be audited by the Nurse Management Team using the IDT Admission/Readmission Review Worksheet. This ongoing audit will ensure physician and family notification for change in condition and alteration/refusal of	03/13/2011

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	in regard to the resident's refusal of the vaccine. An authorization form giving permission for the facility to administer the vaccine had been signed by the Power of Attorney on 9/18/10. When interviewed on 2/9/11 at 8:42 A.M., the DNS, who had only been employed by the facility for 1 week, indicated the physician and the family should have been notified. 2. The clinical record of Resident #22 was reviewed on 2/10/11 at 2:15 P.M., and indicated an admission date of 11/2/10, and diagnoses which included, but were not limited to, dementia and history of breast cancer with mastectomy. A physician's order, dated 1/10/11, indicated "vitamin D 50,000 U (units) Q (every) wk (week) po (oral) x 8 wks...." Review of the January 2011 MAR (medication administration record) indicated the resident received the vitamin D on 1/11/11. On 1/13/11, the resident was admitted to the hospital and returned to the facility on 1/18/11. There was no order for the vitamin D 50,000 units on the discharge medication orders and there was no documentation to indicate the physician had been consulted in regard to the vitamin D.		treatment as well as immunization administration.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**Licensed Nurses will be in-serviced on 3/10/2011. This in-service will include review of the facility policy titled,"Resident Change of Condition" as well as the policy titled, "Nursing Admission/Return Admission Procedure". This in-service will include review of notification and documentation guidelines for refusal of medications, treatment, and clarification of re-admission orders. The nurse managers will review the 24 Hour Condition Report daily to identify any significant change in condition, refusal of medications, refusal of treatments, etc... The admission/re-admission physician orders will be reviewed by two licensed nurses to ensure accurate transcription of all orders.**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**An, "Admission/Readmission Procedure" CQI tool will be utilized weekly x4 and monthly thereafter to monitor ongoing compliance with this finding. In addition the facility will utilize the CQI tool titled, "24 Hour Condition	

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	The resident was transferred to the hospital again on 1/31/11 and returned to the facility on 2/2/11. Again, there was no order in regard to the vitamin D 50,000 units on the hospital discharge orders. There was no documentation the physician had been consulted in regard to the order for the weekly vitamin D 50,000 units. During interview on 2/11/11 at 9:30 A.M., the DNS indicated she could not find documentation of consulting with the physician in regard to continuation of the vitamin D 50,000 units every week for 8 weeks.		Report" weekly x4 weeks and then monthly thereafter. The "Refusal of Medication and Treatment" CQI tool will be utilized weekly x4 then monthly thereafter. Findings will be submitted to the CQI Committee for review and follow up.The DNS and/or designee will be responsible for the program compliance. Compliance Date: 03/13/2011	

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F0157 SS=D	3. The closed clinical record of Resident #87 was reviewed on 2/9/11 at 2:15 p.m., and indicated the resident had diagnoses including, but not limited to, hypothyroidism and left hip intertrochanteric fracture. The Physician's Order dated 10/30/10, indicated the resident had an order for levothyroxine 100 micrograms (used for hypothyroidism) administer one tablet once a day. The Physician's Order Sheet dated November 2010, indicated the resident had an order since 10/7/10, for a multivitamin one tablet once a day and an order since 10/27/10, for the medication Remeron 15 milligrams (used as an appetite stimulant) administer one tablet once a day at bedtime. The Medication Administration Record dated 1/2011, indicated the 5 a.m. dose of levothyroxine 100 micrograms, the Remeron 15 milligrams one tablet at bedtime, and the multivitamin one tablet once a day were circled as not given from 1/1/11 through 1/3/11. The Nurses Notes dated 1/1 through 1/3/11, indicated the Physician had not been notified of the medication refusals.	F0157	**F 0157What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**It is the practice of this provider to promptly inform the resident, consult with the resident's physician, and notify the resident's legal representative or interested family member when there is a significant change in the resident's physical, mental, or psychosocial status and/or the need to alter treatment significantly.Resident # 42 flu vaccine was given on 11/09/2010.Resident # 22 physician was contacted and informed of medication discrepancy.Resident # 87 has been discharged from the facility.The above mentioned residents experienced no negative outcome as a result of this finding.**How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?**All residents have the potential to be affected by this finding. Newly admitted or readmit residents' medical record will be audited by the Nurse Management Team using the IDT Admission/Readmission Review Worksheet. This ongoing audit will ensure physician and family notification for change in condition and alteration/refusal of	03/13/2011

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	On 2/10/11 at 1:45 p.m., the ADNS (Assistant Director Nursing Services) was interviewed in regard to the Physician's notification of the resident's refusals of medication for three consecutive days. The ADNS indicated the Physician should had been notified after the third day of consecutive medication refusal. The policy for Resident Refusal of Medication, dated as revised on 3/10, and reviewed on 2/10/11 at 1:45 p.m., indicated "...Policy It is the policy of this facility to allow the resident the right to refuse services provided including medications... This provider also recognizes that it is the facility responsibility as a healthcare provider to ensure that the residents entrusted to our care receive care and services to attain and maintain the highest level of functioning physically, mentally and psychosocially... Procedure 5. If a resident refuses administration of a medication...for three (3) consecutive days, the physician ...will be contacted and made aware of the refusals." 3.1-5(a)(3)		treatment as well as immunization administration.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**Licensed Nurses will be in-serviced on 3/10/2011. This in-service will include review of the facility policy titled,"Resident Change of Condition" as well as the policy titled, "Nursing Admission/Return Admission Procedure". This in-service will include review of notification and documentation guidelines for refusal of medications, treatment, and clarification of re-admission orders. The nurse managers will review the 24 Hour Condition Report daily to identify any significant change in condition, refusal of medications, refusal of treatments, etc... The admission/re-admission physician orders will be reviewed by two licensed nurses to ensure accurate transcription of all orders.**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**An, "Admission/Readmission Procedure" CQI tool will be utilized weekly x4 and monthly thereafter to monitor ongoing compliance with this finding. In addition the facility will utilize the CQI tool titled, "24 Hour Condition	

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			Report" weekly x4 weeks and then monthly thereafter. The "Refusal of Medication and Treatment" CQI tool will be utilized weekly x4 then monthly thereafter. Findings will be submitted to the CQI Committee for review and follow up.The DNS and/or designee will be responsible for the program compliance. Compliance Date: 03/13/2011	

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F0164	Based on observation and interview, the facility failed to maintain privacy during treatments in regard to closing the privacy curtains and closing the door (Resident #80, Resident #74, Resident #45, and Resident #67). This deficiency affected 3 residents in a sample of 18 and 1 resident in the supplemental sample of 2. Findings include: 1. On 2/8/11 at 10:50 A.M., nurse #20 was observed giving a bolus enteral feeding through a G (gastrostomy) tube. Resident #80 was in the bed adjacent to the door and was the only resident in the room at this time. Nurse #20 did not close the room door or pull the privacy curtains around the bed. During the process the resident's abdomen was exposed. 2. On 2/11/11 at 9:50 A.M., CNA (certified nursing assistant) #21 entered the room of resident #74 to check the resident for incontinence. The resident was in the bed adjacent to the door. The other bed was occupied and the curtain between the beds was slightly pulled. The CNA did not close the room door or pull the privacy curtains around the bed but proceeded to pull the covers off	F0164	**F 0164** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that each resident has the right to personal privacy and confidentiality in regards to personal care and medical treatment. Resident # 80, resident # 74, resident # 67, and resident # 45 experienced no negative outcome as a result of this finding. Any identified staff members will be thoroughly in-serviced and re-educated on resident dignity. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding and will be identified through routine/ random nurse rounds. Any concerns identified will be corrected immediately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all staff in-service will be held on 03/10/2011. This in-service will include review of the facility policy titled “Resident Rights”. This in-service will also include review of the privacy practices such as	03/13/2011

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	resident #74 exposing her body. During interview on 2/11/11 at 1:50 P.M., the DNS (Director of Nursing Services) indicated the doors should have been closed and the privacy curtains should have been pulled.		use of privacy curtains and closed doors during personal care and medication and treatment administration. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To monitor for compliance of this corrective action, the Executive Director, Social Service Director, or other designee will be responsible for completion of the CQI audit tool titled "Dignity/Privacy" weekly x4, monthly x3 and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	

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F0164	3. During medication administration on 2/8/11 at 4:30 p.m., LPN # 5 was observed to obtain a drop of blood from Resident #45 during an accu-check procedure and also to administer an insulin injection, without closing the door to the resident's room, resulting in the abdomen and lower half of Resident #45's body being exposed and visible from the hallway. LPN #5 had closed the privacy curtain between the two residents in the room. 4. On 2/8/11 at 4:55 p.m., LPN # 6 was observed to not close the resident's door while providing care to Resident # 67, resulting in the abdomen and lower half of Resident #67's body being exposed and visible from the hallway. LPN #6 administered medications by gastrostomy tube (a tube placed in the abdomen used to provide the resident with nourishment and medications). 3.1-3(p)(2) 3.1-3(p)(4)	F0164	**F 0164** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that each resident has the right to personal privacy and confidentiality in regards to personal care and medical treatment. Resident # 80, resident # 74, resident # 67, and resident # 45 experienced no negative outcome as a result of this finding. Any identified staff members will be thoroughly in-serviced and re-educated on resident dignity. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding and will be identified through routine/ random nurse rounds. Any concerns identified will be corrected immediately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all staff in-service will be held on 03/10/2011. This in-service will include review of the facility policy titled “Resident Rights”. This in-service will also include review of the privacy practices such as	03/13/2011

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			use of privacy curtains and closed doors during personal care and medication and treatment administration. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To monitor for compliance of this corrective action, the Executive Director, Social Service Director, or other designee will be responsible for completion of the CQI audit tool titled "Dignity/Privacy" weekly x4, monthly x3 and then quarterly thereafter. Data will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	

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F0224 SS=D	Based on observation, interviews, and record review, the facility failed to ensure a resident was not mistreated during care, resulting in a bruise to the inner right forearm, for 1 of 11 residents who sustained falls or bruising in a sample of 18. (Resident #48). Finding includes: Following the Group Interview, on 02/08/11 between 9:15 a.m. and 10:15 a.m., Resident #48 indicated an area of bruising to the right inner forearm above the wrist. The area was observed as deep red-purple in color and measuring approximately 5 cm (centimeters) X 4 cm in size. Resident #48 indicated she had reported the bruise Tuesday morning, 02/08/11, and believed the bruise happened during a transfer with bathing on Friday, 02/04/11, while assisted by a male CNA (Certified Nursing Assistant). Resident #48 indicated she was uncertain, but thought the shower occurred, "early morning." The resident indicated the male CNA "doesn't realize how easily I bruise." The record for Resident #48 was reviewed on 02/10/11 at 2:50 p.m. The record indicated the resident had diagnoses including, but not limited to, peripheral	F0224	**F 0224What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property. It is also the practice of this provider that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility or other designee and to other officials in accordance with state law through established procedures. Resident # 48's identified bruise has resolved. All direct care staff have been updated on her current status and level of assistance required for transfers and care. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. An all staff in-service will be held on 03/10/2011. This in-service will include review of the facility policy and procedure titled, "Abuse Prohibition, Reporting and Investigation". Any allegation or statement regarding resident	03/13/2011

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	neuropathy, PVD (Peripheral Vascular Disease: poor circulation/blood perfusion), pacemaker, and osteoporosis. Review of the most recent MDS (Minimum Data Set) assessment indicated Resident #48 was slightly cognitively impaired and required extensive assistance of two or more for transfers from the bed to chair. The MDS indicated Resident #48 required moderate assistance of one staff with bathing. Review of the "CNA Worksheet", dated "02/04/2011: 10 a.m.", indicated Resident #48 received showers on Tuesdays and Fridays during day shift. Interview with the resident's POA (Power of Attorney), on 02/10/11 at 1:50 p.m., indicated the facility notified the POA by phone on 02/07/11 at 10:30 p.m. of an area of bruising on the right arm of Resident #48. The POA believed, from interview with Resident #48, the area occurred early on day shift on Friday, 02/04/11. A copy of a "FACILITY INCIDENT REPORTING FORM", was provided by the Administrator on 02/10/11 at 2:50 p.m. At this time, the Administrator indicated the form was faxed to the ISDH (Indiana State Department of Health) on 02/10/11 and the investigation was		abuse or mistreatment will be reported immediately to the Administrator and DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH, and other agencies as outlined in the facility policy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A comprehensive head to toe assessment is completed on admission, re-admission, and transfer/discharge and at least weekly by the Charge Nurses. Any new findings such as skin tears, bruising, etc…will be documented in the clinical record. In addition, residents who receive assistance with bathing and toileting care will be observed daily by the nursing staff and any new areas of concern noted will be reported to the Charge Nurse for further assessment. The facility will immediately initiate an internal investigation process to determine the probable cause and to ensure proper follow up. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DNS or other designee will be responsible for completion of the CQI audit tool titled, “Abuse Prohibition and	

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	complete. The Administrator indicated becoming aware of the incident following the group meeting during the morning of 02/08/11. Review of a form, titled, "RESIDENT/FAMILY CONCERN/GRIEVANCE FORM", indicated the concern was received on 02/09/11 by the Consultant RN for the corporation. Review of the form indicated: "Date of Concern: 02/07/11" "Time of Concern: 2030 (8:30 p.m.)" "Date Concern Received: 02/09/11": "on 02/09/11 SS (Social Services) and Nursing (name) spoke c (with) (Resident #48 name) & (and) daughter (name). (Resident #48) stated 'CNA, he had to get a hold of me in shower & he held my arm too hard.'...(resident) 'just doesn't like his ways...'...(resident) stated, 'so many can get me up & are gentle.'" Further investigation remarks indicated the resident was unable to identify the staff member beyond gender. Attached to the investigation were two written statements, from an LPN and a CNA, both female, and dated 02/07/11. There was no further information to indicate the facility had interviewed staff who were working on the day of the alleged incident.		Investigation" and "Abuse" weekly x4 then monthly x3 and then quarterly thereafter to monitor for ongoing compliance. Any trends or findings will be submitted to the CQI Committee for review and follow up. Compliance date: 03/13/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING _____ B. WING _____	02/11/2011

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	Review of a facility Policy and Procedure, titled, "ABUSE PROHIBITION, REPORTING, AND INVESTIGATION (February 2010)", provided by the Administrator on 02/07/11, following the Entrance Conference, indicated: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds." "Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or pain, or mental anguish...." "...Neglect-failure to provide goods and services necessary to avoid physical harm,...Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents...." "5. All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative...within 24 hours of the report.... 6. The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed...." 7. The Executive Director/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health...." 3.1-27(a)(3)			

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F0225 SS=D	Based on observation, interviews, and record review, the facility failed to immediately report and thoroughly investigate an allegation of mistreatment resulting in a bruise, for 1 of 11 residents reviewed who sustained falls or bruising in a sample of 18. (Resident #48). Finding includes: Following the Group Interview, on 02/08/11 between 9:15 a.m. and 10:15 a.m., Resident #48 indicated an area of bruising to the right inner forearm above the wrist. The area was observed as deep red-purple in color and measuring approximately 5 cm (centimeters) X 4 cm in size. Resident #48 indicated she had reported the bruise Tuesday morning, 02/08/11, and believed the bruise happened during a transfer with bathing on Friday, 02/04/11, while assisted by a male CNA (Certified Nursing Assistant). Resident #48 indicated she was uncertain, but thought the shower occurred, "early morning." The resident indicated the male CNA "doesn't realize how easily I bruise." The record for Resident #48 was reviewed on 02/10/11 at 2:50 p.m. The record indicated the resident had diagnoses including, but not limited to, peripheral	F0225	**F0225** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property. It is also the practice of this provider that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility or other designee and to other officials in accordance with state law through established procedures. Resident # 48's identified bruise has resolved. All direct care staff have been updated on her current status and level of assistance required for transfers and care. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. An all staff in-service will be held on 03/10/2011. This in-service will include review of the facility policy and procedure titled, "Abuse Prohibition, Reporting and Investigation". Any allegation or	03/13/2011

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	neuropathy, PVD (Peripheral Vascular Disease: poor circulation/blood perfusion), pacemaker, and osteoporosis. Review of the most recent MDS (Minimum Data Set) assessment indicated Resident #48 was slightly cognitively impaired and required extensive assistance of two or more for transfers from the bed to chair. The MDS indicated Resident #48 required moderate assistance of one staff with bathing. Review of the "CNA Worksheet", dated "02/04/2011: 10 a.m.", indicated Resident #48 received showers on Tuesdays and Fridays during day shift. Interview with the resident's POA (Power of Attorney), on 02/10/11 at 1:50 p.m., indicated the facility notified the POA by phone on 02/07/11 at 10:30 p.m. of an area of bruising on the right arm of Resident #48. The POA believed, from interview with Resident #48, the area occurred early on day shift on Friday, 02/04/11. A copy of a "FACILITY INCIDENT REPORTING FORM", was provided by the Administrator on 02/10/11 at 2:50 p.m. At this time, the Administrator indicated the form was faxed to the ISDH (Indiana State Department of Health) on 02/10/11 and the investigation was		statement regarding resident abuse or mistreatment will be reported immediately to the Administrator and DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH, and other agencies as outlined in the facility policy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A comprehensive head to toe assessment is completed on admission, re-admission, and transfer/discharge and at least weekly by the Charge Nurses. Any new findings such as skin tears, bruising, etc…will be documented in the clinical record. In addition, residents who receive assistance with bathing and toileting care will be observed daily by the nursing staff and any new areas of concern noted will be reported to the Charge Nurse for further assessment. The facility will immediately initiate an internal investigation process to determine the probable cause and to ensure proper follow up. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DNS or other designee will be responsible for completion of	

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	complete. The Administrator indicated becoming aware of the incident following the group meeting during the morning of 02/08/11. Review of a form, titled, "RESIDENT/FAMILY CONCERN/GRIEVANCE FORM", indicated the concern was received on 02/09/11 by the Consultant RN for the corporation. Review of the form indicated: "Date of Concern: 02/07/11" "Time of Concern: 2030 (8:30 p.m.)" "Date Concern Received: 02/09/11": "on 02/09/11 SS (Social Services) and Nursing (name) spoke c (with) (Resident #48 name) & (and) daughter (name). (Resident #48) stated 'CNA, he had to get a hold of me in shower & he held my arm too hard.'...(resident) 'just doesn't like his ways...'...(resident) stated, 'so many can get me up & are gentle.'" Further investigation remarks indicated the resident was unable to identify the staff member beyond gender. Attached to the investigation were two written statements, from an LPN and a CNA, both female, and dated 02/07/11. There was no further information to indicate the facility had interviewed staff who were working on the day of the alleged incident.		the CQI audit tool titled, "Abuse Prohibition and Investigation" and "Abuse" weekly x4 then monthly x3 and then quarterly thereafter to monitor for ongoing compliance. Any trends or findings will be submitted to the CQI Committee for review and follow up. Compliance date: 03/13/2011	

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	Review of a facility Policy and Procedure, titled, "ABUSE PROHIBITION, REPORTING, AND INVESTIGATION (February 2010)", provided by the Administrator on 02/07/11, following the Entrance Conference, indicated: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds." "Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or pain, or mental anguish...." "...Neglect-failure to provide goods and services necessary to avoid physical harm,...Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents...." "5. All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative...within 24 hours of the report.... 6. The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed...." 7. The Executive Director/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health...." 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F0226 SS=D	Based on observation, interviews, and record review, the facility failed to follow their abuse prevention policy and procedure in regard to the thorough investigation of a bruise incurred during resident care for 1 of 11 residents who sustained falls or bruising in a sample of 18. (Resident #48). Finding includes: Review of a facility Policy and Procedure, titled, "ABUSE PROHIBITION, REPORTING, AND INVESTIGATION (February 2010)", provided by the Administrator on 02/07/11, following the Entrance Conference, indicated: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds." "Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or pain, or mental anguish...." "...Neglect-failure to provide goods and services necessary to avoid physical harm,...Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents...." "5. All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative...within 24 hours of the report.... 6. The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed...." 7. The Executive Director/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health...."	F0226	**F 0226What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident's property. It is also the practice of this provider that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility or other designee and to other officials in accordance with state law through established procedures. Resident # 48's identified bruise has resolved. All direct care staff have been updated on her current status and level of assistance required for transfers and care. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. An all staff in-service will be held on 03/10/2011. This in-service will include review of the facility policy and procedure titled, "Abuse Prohibition, Reporting and Investigation". Any allegation or statement regarding resident	03/13/2011

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	Following the Group Interview, on 02/08/11 between 9:15 a.m. and 10:15 a.m., Resident #48 indicated an area of bruising to the right inner forearm above the wrist. The area was observed as deep red-purple in color and measuring approximately 5 cm (centimeters) X 4 cm in size. Resident #48 indicated she had reported the bruise Tuesday morning, 02/08/11, and believed the bruise happened during a transfer with bathing on Friday, 02/04/11, while assisted by a male CNA (Certified Nursing Assistant). Resident #48 indicated she was uncertain, but thought the shower occurred, "early morning." The resident indicated the male CNA "doesn't realize how easily I bruise." The record for Resident #48 was reviewed on 02/10/11 at 2:50 p.m. The record indicated the resident had diagnoses including, but not limited to, peripheral neuropathy, PVD (Peripheral Vascular Disease: poor circulation/blood perfusion), pacemaker, and osteoporosis. Review of the most recent MDS (Minimum Data Set) assessment indicated Resident #48 was slightly cognitively impaired and required extensive assistance of two or more for transfers from the bed to chair. The MDS indicated Resident #48 required moderate		abuse or mistreatment will be reported immediately to the Administrator and DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH, and other agencies as outlined in the facility policy. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A comprehensive head to toe assessment is completed on admission, re-admission, and transfer/discharge and at least weekly by the Charge Nurses. Any new findings such as skin tears, bruising, etc…will be documented in the clinical record. In addition, residents who receive assistance with bathing and toileting care will be observed daily by the nursing staff and any new areas of concern noted will be reported to the Charge Nurse for further assessment. The facility will immediately initiate an internal investigation process to determine the probable cause and to ensure proper follow up. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DNS or other designee will be responsible for completion of the CQI audit tool titled, “Abuse Prohibition and	

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	assistance of one staff with bathing. Review of the "CNA Worksheet", dated "02/04/2011: 10 a.m.", indicated Resident #48 received showers on Tuesdays and Fridays during day shift. Interview with the resident's POA (Power of Attorney), on 02/10/11 at 1:50 p.m., indicated the facility notified the POA by phone on 02/07/11 at 10:30 p.m. of an area of bruising on the right arm of Resident #48. The POA believed, from interview with Resident #48, the area occurred early on day shift on Friday, 02/04/11. A copy of a "FACILITY INCIDENT REPORTING FORM", was provided by the Administrator on 02/10/11 at 2:50 p.m. At this time, the Administrator indicated the form was faxed to the ISDH (Indiana State Department of Health) on 02/10/11 and the investigation was complete. The Administrator indicated becoming aware of the incident following the group meeting during the morning of 02/08/11. Review of a form, titled, "RESIDENT/FAMILY CONCERN/GRIEVANCE FORM", indicated the concern was received on 02/09/11 by the Consultant RN for the		Investigation" and "Abuse" weekly x4 then monthly x3 and then quarterly thereafter to monitor for ongoing compliance. Any trends or findings will be submitted to the CQI Committee for review and follow up. Compliance date: 03/13/2011	

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	corporation. Review of the form indicated: "Date of Concern: 02/07/11" "Time of Concern: 2030 (8:30 p.m.)" "Date Concern Received: 02/09/11": "on 02/09/11 SS (Social Services) and Nursing (name) spoke c (with) (Resident #48 name) & (and) daughter (name). (Resident #48) stated 'CNA, he had to get a hold of me in shower & he held my arm too hard.'...(resident) 'just doesn't like his ways...'...(resident) stated, 'so many can get me up & are gentle.'" Further investigation remarks indicated the resident was unable to identify the staff member beyond gender. Attached to the investigation were two written statements, from an LPN and a CNA, both female, and dated 02/07/11. There was no further information to indicate the facility had interviewed staff who were working on the day of the alleged incident. 3.1-28(a)			

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F0241	Based on confidential interviews, the facility failed to ensure dignity was maintained during resident care as defined by direct care staff answering personal cell phones, engaging in personal conversations with each other, and not communicating with residents while providing direct personal care. This deficiency affected 5 of 8 residents who attended the group meeting and/or residents and families who were confidentially interviewed (Resident Q). Finding includes: Between 02/07/11 and 02/11/11, confidential interviews were conducted with a group meeting of residents, individual residents and family members who represented residents residing on 3 of 3 units. Confidential interviews and 5 of 8 residents who attended the group meeting indicated a concern in regard to direct care staff providing care. The interviews indicated direct care staff had been observed by residents and family members to engage in personal conversations without acknowledging the resident receiving care. The interviews indicated direct care staff had been observed to answer personal cell phones while in resident rooms when providing care. Those interviewed indicated this	F0241	**F 0241** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. There were no specific residents identified in regards to this finding. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all staff in-service will be conducted on 03/10/2011. This in-service will include review of the facility policy titled "Resident Rights". This in-service will also include review of the procedure for maintaining dignity during resident care. Staff will be re-educated regarding practices such as engaging in personal conversations with co-workers while providing direct personal care to residents. All staff will also	03/13/2011

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	was observed with residents who were cognitively impaired as well as those who were alert and oriented. A confidential interview with Resident Q indicated, " Some of those poor people may not know what ' s going on but they (staff) should not be answering phones and talking over them. " Interview with the Consultant RN for the corporation, the DNS (Director Nursing Services), and the Administrator, on 02/10/11 at 9:00 a.m., indicated the facility did not routinely follow-up on residents in the facility in regards to general care and services. 3.1-3(t)		be re-educated on facility policy regarding cell phone use. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To monitor for ongoing compliance of this corrective action the ED, SSD, or other designee will be responsible for completion of the CQI audit tool titled, “Dignity and Privacy”, weekly x4 and then monthly thereafter. Data will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	

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F0253	Based on observation and interview, the facility failed to provide necessary service to ensure a sanitary and clean environment in regard to cleaning and maintaining toilet grab bars and cleaning of the popcorn machine area. This deficiency affected 2 of 2 residents residing in room 106 and any residents from the Heritage unit or the Liberty unit utilizing the activity room popcorn machine. Findings include: 1. During the environmental tour on 2/8/11 at 1:25 P.M., accompanied by the maintenance and the housekeeping supervisors, the following was observed: In room 106 on the Heritage unit, the area behind the toilet seat, where the toilet grab bar was attached, was filled with loose flakes of white paint. When queried at this time, the maintenance supervisor indicated the bars where painted with white enamel paint and the toilet bowel cleaner was causing the paint to chip off. 2. The popcorn machine in the activity room was sitting on a cart. There was food debris and dust on the cart surrounding the popcorn machine. There	F0253	**F 0253** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to provide necessary service to maintain a sanitary, orderly and comfortable interior. Room 106 on the Heritage Unit: the toilet grab bar has been replaced. The popcorn machine and surrounding cart has been cleaned. No specific residents were identified to be affected by this finding. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all staff in-service will be held on 03/10/2011. This in-service will include review of the procedure regarding routine cleaning, repair, and maintenance request slips. All staff will be informed of the routine cleaning schedule for the popcorn machine. **How will the corrective**	03/13/2011

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	was also dust on the shelf underneath the popcorn machine. The housekeeping supervisor indicated the popcorn machine was frequently used. 3.1-19(f)		**action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored through completion of the CQI audit tool titled, “Facility, Environmental Review”. This audit tool will be completed weekly x4 and then monthly thereafter. The Executive Director, Maintenance Director, Activity Director, or other designee is responsible for program compliance. Date will be submitted to the CQI Committee for review and follow up. Completion Date: 03/13/2011	

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F0279 SS=D	Based on interviews and record reviews, the facility failed to develop a care plan for 1 of 1 resident with an intravenous port for chemotherapy in a sample of 18. (Resident #30) Findings include: The clinical record of Resident # 30 was reviewed on 2/9/11 at 9:00 a.m., and indicated the resident had diagnoses including, but not limited to, low grade marginal zone lymphoma. Resident #30 was receiving chemotherapy with the most recent dose documented as 02/08/11. The nurses notes dated 12/10/10, indicated the resident had a port placed for chemotherapy. There was no care plan for the resident's intravenous port. On 2/9/11 at 2:30 p.m., the Minimum Data Set (MDS) Assessment Coordinator was interviewed in regard to no care plan for the Intravenous port for chemotherapy. The MDS Coordinator indicated she did not develop a care plan, and the resident should have had a care plan in place for the intravenous port. On 2/10/11 at 1:30 p.m., the DNS (Director of Nursing Services) was queried in regard to the nurses checking the port and the DNS indicated she did receive a physician's order to check the port site every shift for signs and symptoms of infection.	F0279	**F0279** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. Resident # 30's care plan has been reviewed and updated to reflect her current status. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. All resident's care plans will be reviewed and revised during the next 90 days by the IDT team to ensure accuracy and appropriateness. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All disciplines will participate in the development and ongoing revisions to the plan of care. The 24 Hour Condition Report is reviewed daily by all disciplines to ensure information regarding resident condition such as placement of an intravenous port and physician order changes are utilized to develop and update	03/13/2011

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	On 2/11/11 at 8:20 a.m. the Director of Nursing Services (DNS) provided Nurses Notes dated 12/10/10 through 1/13/11, that indicated the nurses documented consistently on the intravenous port. There were no other Nurses Notes after 1/13/11, provided by the DNS in regard to the intravenous port. 3.1-35(a)		each resident's plan of care. A Nursing in-service will be held on 3/10/2011. This in-service will include review of the facility policy titled, "Care Plan Review". **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI audit tool titled, "Care Plan Updating" will be completed weekly x4, monthly x3 and then quarterly thereafter by the MDS Coordinator and other designee. Findings will be submitted to the CQI Committee for review and follow up. The DNS, MDS Coordinator and/or designee will be responsible for program compliance. Compliance Date: 03/13/2011	

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F0282	Based on record review, interview, and observation, the facility failed to follow physician orders for laboratory blood tests (Residents #67, #33, #74), failed to correctly transcribe an order for medication (Resident #45), and failed to follow care plans in regard to following recommendations for resident safety and to prevent falls (Residents #87, #17). This deficiency affected 6 of 18 residents reviewed for following physician orders and care plans in a sample of 18. Findings include: 1. The clinical record of Resident #67 was reviewed on 2/10/11 at 10:25 A.M., and indicated diagnoses which included, but were not limited to, CVA (cerebral vascular accident - stroke), CHF (congestive heart failure) and diabetes mellitus. A physician's order, dated 12/20/10, indicated a hepatic panel was to be done. There was no documentation to indicate the laboratory test had been done. During interview on 2/10/11 at 3:15 P.M., the DNS (Director of Nursing Services) indicated the hepatic panel had not been done as ordered. 2. The clinical record of Resident #33	F0282	**F 0282** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that services must be provided by qualified persons in accordance with each resident's written plan of care. Residenti# 67's physician was notifed and new lab orders were received. Residenti# 33 has been discharged from tihe facilitiy Residenti# 74's physician was notifed and labs were drawn as ordered. Residenti# 45's physician was notifed of medication discrepancy . The physician is aware of currenti stiatius and is aware of currenti Coumadin dosage. Residenti# 87 has been discharged from tihe facilitiy Resident # 17's care plan has been reviewed and updated to reflect current interventions. All direct care staff have been in-serviced/re-educated on specific safety interventions listed on the care plan for this identified resident. None of the identified residents experienced any negative outcome as a result of this finding. **How will you identify other residents having the potential**	03/13/2011

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	was reviewed on 2/9/11 at 10:10 A.M., and indicated an admission date of 12/20/10, and diagnoses which included, but were not limited to, CHF (congestive heart failure), aortic valve disease and COPD (chronic obstructive pulmonary disease). Review of the January and February 2011 physician order forms indicated the resident was receiving Coumadin (a blood thinning medication) daily, the dosage determined by the PT/INR laboratory results. A physician's order, dated 2/1/11, indicated the Coumadin should be held until 2/7/11 and the PT/INR laboratory tests should be done on 2/7/11, and start Coumadin 3 mg daily on 2/7/11. There was no documentation to indicate the PT/INR had been done on 2/7/11 as ordered. During interview on 2/11/11 at 9:30 A.M., the DNS indicated the order for the PT/INR on 2/7/11, had been missed. 3. The clinical record of Resident #74 was reviewed on 2/9/11 at 1:40 P.M., and indicated diagnoses which included, but were not limited to, dementia and contact dermatitis.		**to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding and will be identified through a facility audit of the following: laboratory review, physician order review, and fall care plan review. These audits will ensure labs are being obtained and followed as ordered, physician orders have been transcribed correctly, and fall prevention and safety interventions are being followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all nursing staff in-service will be held on 03/10/2011. This in-service will include review of the following facility policies: "Guidelines for Lab Tracking", "Medication and Treatment Administration Record" and "Fall Management Program". **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this corrective action the DNS or designee will utilize the following CQI audit tools: "Change in Condition", "Laboratory and Diagnostic" and "Care Plan Updating" weekly x4	

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	A physician's order, dated 10/11/10, indicated a pre-albumin level and a vitamin D 25 hydroxy level were to be done. There was no documentation to indicate the laboratory tests had been done. During interview on 2/11/11 at 9:30 A.M., the DNS indicated the tests had not been done.		and monthly thereafter. Findings will be submitted to the CQI committee for review and follow up. Compliance Date: 03/13/2011	

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F0282	4. The closed clinical record of Resident #87 was reviewed on 2/9/11 at 2:15 p.m., and indicated the resident had diagnoses which included, but were not limited to, fractured hip and dementia. The Interdisciplinary Team progress notes (IDT) dated 11/30/10, indicated "...IDT F/U (follow up). Resident found on floor on 11/29/10 at 1715 (5:15 p.m.), she had previously been in recliner in TV lounge, and attempted to get up per self. Resid (resident) had tab alarm to bed and w/c (wheelchair). Alarm was not placed in recliner (c) (with) her. She was fully dressed (c) shoes on. Resid has severe dementia and et (and) exhibits poor safety awareness...." The Care Plan dated 10/18/10, indicated "...resident is at risk for falls due to hx (history) of falls, hx of recent hip fracture, requires assist with mobility and transfers, dx (diagnosis) dementia...Interventions... chair alarm to alert staff of attempts to transfer unassisted...." 5. The clinical record of Resident # 45 was reviewed on 2/8/11 at 1:30 p.m., and indicated the resident had diagnoses which included, but were not limited to, chronic atrial fibrillation.	F0282	**F 0282** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that services must be provided by qualified persons in accordance with each resident's written plan of care. Residenti# 67's physician was notifed and new lab orders were received. Residenti# 33 has been discharged from tihe facilitiy Residenti# 74's physician was notifed and labs were drawn as ordered. Residenti# 45's physician was notifed of medication discrepancy . The physician is aware of currenti stiatius and is aware of currenti Coumadin dosage. Residenti# 87 has been discharged from tihe facilitiy Resident # 17's care plan has been reviewed and updated to reflect current interventions. All direct care staff have been in-serviced/re-educated on specific safety interventions listed on the care plan for this identified resident. None of the identified residents experienced any negative outcome as a result of this finding. **How will you identify other residents having the potential**	03/13/2011

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	The physician telephone orders dated 1/26/11 at 1930 (7:30 p.m.), indicated start Coumadin two milligrams one tablet by mouth every day. The Medication Administration Record (MAR) dated 1/27/11 through 1/31/11, indicated the resident had received Coumadin two milligrams one tablet every day. The Physician's Order Sheet (POS) dated February 2011, indicated an order for "warfarin sodium (Coumadin) 2 MG (milligrams) tablet ...Coumadin 2 MG tablet give 2 tablet orally once a day...." The order for the Coumadin dated 1/19/11 and was crossed off and the date 1/26/11 was written in on the POS. The Coumadin dosage for two milligrams and two tablets was also written in on the POS. The MAR dated February 2011, indicated an order for "warfarin sodium 2 (Two) MG (milligrams) tablet ...Coumadin 2 MG tablet give 2 tablet orally once a day...." On the MAR, the Coumadin order dated 1/19/11 and was crossed off, and the date 1/26/11 was written in. The Coumadin dosage for two milligrams and two tablets was also written in. The Coumadin 2 mg		**to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding and will be identified through a facility audit of the following: laboratory review, physician order review, and fall care plan review. These audits will ensure labs are being obtained and followed as ordered, physician orders have been transcribed correctly, and fall prevention and safety interventions are being followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all nursing staff in-service will be held on 03/10/2011. This in-service will include review of the following facility policies: "Guidelines for Lab Tracking", "Medication and Treatment Administration Record" and "Fall Management Program". **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this corrective action the DNS or designee will utilize the following CQI audit tools: "Change in Condition", "Laboratory and Diagnostic" and "Care Plan Updating" weekly x4	

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	administer 2 tablets were signed as given on 2/1 through 2/4/11 at 5:00 p.m., Also written in on the MAR was "...D/C (discontinue) Rewritten- clarification 2/5/11...." On the MAR dated 2/5/11 at 5:00 p.m., the order for warfarin administer 2 mg give 1 tablet once a day. A Medication Error Report dated 2/9/11, was provided and reviewed on 2/10/11 at 9:15 a.m., indicated "...Date of error 2/1 - 2/4/11...Error made during transcription of P.O.S rewrites. I crossed off (one) mg and (changed) to 2 mg tab (tablet) but on order below dose - Wrote give 2 tablets po (by mouth) once daily and forgot to write mg behind 2...Nurse doing 2nd (second) checks also failed to (too)...How was the error discovered? Nurse questioned order on 2/5 and clarified it...." On 2/10/11 at 9:15 a.m., the Director of Nursing Services (DNS) was queried in regard to the transcription error for the warfarin that was signed as given on 2/1 through 2/4/11. The DNS indicated the Nurse transcribed the Coumadin order incorrectly and wrote 2 milligrams 2 tablets. The correct dosage was give 2 mg 1 tablet once a day. The DNS also indicated she was awaiting a call back from LPN #5 who had signed the MAR dated 2/1 through 2/4/11.		and monthly thereafter. Findings will be submitted to the CQI committee for review and follow up. Compliance Date: 03/13/2011	

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	On 2/10/11 at 2:15 p.m., LPN #5 was queried in regard to the MAR dated 2/1 through 2/4/11. LPN #5 indicated when she had looked at the 2/2011 MAR she did not read the full order for the warfarin to administer two milligrams two tablets and went by memory of what the resident had received last month. LPN #5 indicated she had signed the MAR for 2/1 through 2/4/11, but she had only given the resident two milligrams one tablet once a day.			

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F0282	6. The record of Resident #17 was reviewed on 02/07/11 at 1:00 p.m. Resident #17 was admitted to the facility on 05/20/10 with diagnoses including, but not limited to, CAD (Coronary Artery Disease), diabetes, CHF (Congestive Heart Failure), dementia, and depression. During the initial tour, on 02/07/11, between 11:00 a.m. and 11:45 a.m., and accompanied by LPN #3, Resident #17 was identified as having incurred a significant bruise to her posterior (back) thigh and being on fall precautions. The CNA Worksheet (a tool to aid in resident care), used during the initial tour, indicated under "SPECIAL NEEDS": "Non skid strips by chair & bed....bed in lowest position...Non skid socks." Resident #17 was observed, during the initial tour, lying awake and atop her bed which was in the lowest position. The resident's room was observed to not have non-skid strips in front of the bed or the chair. There was no evidence of a bed alarm being in place. Observation of the bathroom of Resident #17 indicated a portable commode over the toilet with a bars on both sides and a standard commode seat. Review of a care plan for "06/03/10:	F0282	**F 0282** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that services must be provided by qualified persons in accordance with each resident's written plan of care. Residenti# 67's physician was notifed and new lab orders were received. Residenti# 33 has been discharged from tihe facilitiy Residenti# 74's physician was notifed and labs were drawn as ordered. Residenti# 45's physician was notifed of medication discrepancy . The physician is aware of currenti stiatius and is aware of currenti Coumadin dosage. Residenti# 87 has been discharged from tihe facilitiy Resident # 17's care plan has been reviewed and updated to reflect current interventions. All direct care staff have been in-serviced/re-educated on specific safety interventions listed on the care plan for this identified resident. None of the identified residents experienced any negative outcome as a result of this finding. **How will you identify other residents having the potential**	03/13/2011

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	Resident is at risk for falls and/or has had actual falls", indicated, but was not limited to, the following: "INTERVENTIONS: 02/2011: Bed alarm... 08/02/10 Non-skid strips in front of bed 06/14/10 Non-skid strips in front of chair Review of "IDT (Interdisciplinary Team) Progress Notes", dated 01/25/11 at 1800 (6:00 p.m.), indicated: "IDT review for bruise noted during shower 01/24/11....having resident sit on commode & ease herself c (with) bars on both sides showed the bruised area coming in contact c the edge of the commode seat....nursing recommending possibility of soft commode seat." 3.1-35(g)(2)		**to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding and will be identified through a facility audit of the following: laboratory review, physician order review, and fall care plan review. These audits will ensure labs are being obtained and followed as ordered, physician orders have been transcribed correctly, and fall prevention and safety interventions are being followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all nursing staff in-service will be held on 03/10/2011. This in-service will include review of the following facility policies: "Guidelines for Lab Tracking", "Medication and Treatment Administration Record" and "Fall Management Program". **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this corrective action the DNS or designee will utilize the following CQI audit tools: "Change in Condition", "Laboratory and Diagnostic" and "Care Plan Updating" weekly x4	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			and monthly thereafter. Findings will be submitted to the CQI committee for review and follow up. Compliance Date: 03/13/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING _____ B. WING _____	02/11/2011

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F0323	A. Based on observation and interview, the facility failed to ensure an environment free of hazards in regard to the storage of a portable oxygen (O2) cylinder and response to a door alarm for 1 of 3 units (Heritage hall) in the facility. This deficiency had the potential to effect 37 of 37 residents residing on the Heritage hall unit and any residents who had emergency need of O2. B. Based on record review, the facility failed to ensure supervision to prevent a fall for 1 of 9 residents reviewed for falls in a sample of 18. (resident #87) Findings include: A.1. On 2/8/11 at 1:25 P.M., during the environment tour, accompanied by the maintenance and housekeeping supervisors, a portable oxygen (O2) (compressed gas) cylinder was observed in the clean utility room of the Heritage hall. The regulator was in place on the top of the cylinder, however the cylinder was not in a stand or chained to the wall. The maintenance supervisor indicated the oxygen cylinder was part of the "crash" cart (a cart with supplies to assist in providing residents with acute emergency care) which was also in the room. 37 residents resided on the Heritage hall.	F0323	**F 0323** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that each resident environment remains free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent falls. Resident # 87 has been discharged from the facility. The O2 cylinder has been secured to the wall by a chain. An additional speaker was installed closer to the nurse's station to alert staff if the door is opened. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all staff in-service will be held on 03/10/2011. This in-service will include review of the facility policy titled, "Missing Resident/Resident Elopement" with an emphasis on the importance of immediate response to any safety alarm and/or door alarm. This in-service	03/13/2011

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	2. The door at the top of the Heritage hall opened on to a busy main street. There was a key pad to open the door, but the alarm would sound if the door was pushed to open without using the key pad. The door was pushed open, and the alarm sounded. A laundry staff person was halfway down the hall at the linen cupboard. She did not respond to the alarm. 37 residents, some identified as independently mobile and some who are confused, resided on Heritage hall. At this time, the housekeeping supervisor indicated a light on the board at the nurses station would indicate which door was opened. Although the alarm was not very loud, it could be heard at the nurses station. Several staff members were around the nurses station but did not respond. One CNA (certified nursing assistant) said "what's that" and then went down the hall toward the door. She put the code in the key pad to silence the alarm but did not look out the door. At this time, the unit manager indicated the CNA should have looked outside. During interview on 2/11/11 at 9:30 A.M., the Administrator and the DNS indicated all staff should respond when a door alarm sounds.		will also include review of the policy titled, “Fall Management Program”. Fall prevention and keeping the environment safe and free of hazards will also be discussed. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this corrective action. The DNS or designee will be responsible for completing the CQI audit tool titled “Fall Management” weekly x4 and monthly thereafter. The facility will conduct Elopement Drills weekly x4 and then monthly thereafter. Findings will be submitted to the CQI committee for review and follow up. The ED is responsible for determining the dates and times of the Elopement Drills. A CQI tool titled, “Elopement Procedure” will be completed following each elopement drill. Findings will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	

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F0323	B. The closed clinical record of Resident #87 was reviewed on 2/9/11 at 2:15 p.m., and indicated the resident had diagnoses which included, but were not limited to, fractured hip and dementia. The Interdisciplinary Team progress notes (IDT) dated 11/30/10, indicated "...IDT F/U (follow up). Resident found on floor on 11/29/10 at 1715 (5:15 p.m.), she had previously been in recliner in TV lounge, and attempted to get up per self. Resid (resident) had tab alarm to bed and w/c (wheelchair). Alarm was not placed in recliner (c) (with) her. She was fully dressed (c) shoes on. Resid has severe dementia and et (and) exhibits poor safety awareness...." The Care Plan dated 10/18/10, indicated "...resident is at risk for falls due to hx (history) of falls, hx of recent hip fracture, requires assist with mobility and transfers, dx (diagnosis) dementia...Interventions... chair alarm to alert staff of attempts to transfer unassisted...." 3.1-45(a)(1) 3.1-45(a)(2)	F0323	**F 0323** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that each resident environment remains free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent falls. Resident # 87 has been discharged from the facility. The O2 cylinder has been secured to the wall by a chain. An additional speaker was installed closer to the nurse's station to alert staff if the door is opened. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all staff in-service will be held on 03/10/2011. This in-service will include review of the facility policy titled, "Missing Resident/Resident Elopement" with an emphasis on the importance of immediate response to any safety alarm and/or door alarm. This in-service	03/13/2011

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			will also include review of the policy titled, “Fall Management Program”. Fall prevention and keeping the environment safe and free of hazards will also be discussed. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this corrective action. The DNS or designee will be responsible for completing the CQI audit tool titled “Fall Management” weekly x4 and monthly thereafter. The facility will conduct Elopement Drills weekly x4 and then monthly thereafter. Findings will be submitted to the CQI committee for review and follow up. The ED is responsible for determining the dates and times of the Elopement Drills. A CQI tool titled, “Elopement Procedure” will be completed following each elopement drill. Findings will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	

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F0333 SS=D	Based on record review and interview, the facility failed to assure Insulin coverage was administered as ordered for 14 of 18 evenings of administration reviewed, for 1 of 8 residents receiving insulin in a sample of 18. (Resident #18) Finding includes: The record of resident #18 was reviewed on 02/11/11 at 10:35 a.m. Resident #18 had diagnoses including, but not limited to, diabetes, anemia, depression, and chronic renal disease. Review of physician's orders indicated Resident #18 was to receive sliding scale Insulin (SSI) coverage AC (before meals) as well as insulin coverage at HS (bedtime). The physician's orders indicated: "1/17/11 Humalog Insulin coverage: AC (before meals): 110-125=1u (unit) 126-140=2u 141-160=3u 161-180=4u 181-200=5u 201-240=6u 241-280=7u 281-320=8u 321-360=9u >(greater than) 360=10u & call MD	F0333	**F 0333** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to ensure that all residents be free of any significant medication errors. Resident # 18 continues on sliding scale coverage. New physician orders were received to use the same sliding scale for all blood glucose results. This resident did not experience any negative outcome as result of this finding. The physician is aware of this resident's blood sugar results. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents with orders for Sliding Scale Insulin have the potential to be affected by this finding and will be identified through a facility audit. This audit will ensure that all residents with orders for sliding scale insulin are receiving the appropriate dosage. Any noted discrepancies will be clarified and corrected at the time noted. The Nurse Management Team is responsible for the completion of this audit. **What measures will be put into place or what systemic changes you will make to**	03/13/2011

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	(Medical Doctor) Humalog Insulin coverage: HS (bedtime) 140-160=1u 161-180=2u 181-200=3u 201-220=4u 221-240=5u 241-280=6u 281-320=7u 321-360=8u 361-400=9u >400=10u & call MD A physician's order, dated 01/27/11, indicated: "DC (discontinue) Humalog; start Novulog insulin for SSI." Review of "Capillary Blood Glucose Monitoring Tool" for 01/24/11 through 02/10/11, indicated the following wrong Insulin doses given: "Date: Blood Glucose Reading / Units of Insulin--dosage ordered 01/24/11: 159 / 3u----1u 01/25/11: 207 / 6u----4u 01/26/11: 192 / 5u----3u 01/27/11: 238 / 6u----5u 01/28/11: 168 / 5u----2u 01/29/11: 251 / 7u----6u 01/30/11: 226 / 6u----5u 01/31/11: 222 / 6u----5u 02/01/11: 142 / 3u----1u		**ensure that the deficient practice does not recur?** A nursing in-service will be held on 03/10/2011. This in-service will include review of the facility policy titled, “Blood Glucose Monitoring”. This in-service will also include review of transcription and documentation practices related to blood glucose monitoring. The policy titled,”Medication Error”, will be reviewed at this nursing in-service as well. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this correction action, the DNS and/or designee will be responsible for completing the CQI audit tool titled, “Blood Glucose Machines and Testing/Accu-checks”. This audit tool will be completed weekly x4 weeks and monthly thereafter. Data will be submitted to the CQI Committee for review and follow up. In addition, the CQI audit tool titled, “Medication Errors” will be completed monthly x3 months then quarterly thereafter. Compliance Date: 03/13/2011	

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	02/02/11: 203 / 6u----4u 02/03/11: 169 / 4u----2u 02/05/11: 285 / 8u----7u 02/07/11: 219 / 6u crossed out & 5u marked as given----3u 02/10/11: 237/ 6u----5u Interview with LPN #4 indicated being unaware of the SSI for HS coverage being given wrong. 3.1-25(b)(9) 3-1-48(c)(2)			

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F0334 SS=D	Based on record review and interview, the facility failed to ensure the administration of annual influenza vaccine as ordered and consented for 2 of 18 residents reviewed in a sample of 18 for yearly influenza vaccine (#89, #50) Findings include: 1. The clinical record of Resident # 50 was reviewed on 2/7/11 at 2:00 p.m., and indicated the resident had diagnoses which included, but were not limited to, hypertension and Alzheimer's disease. The physician's order sheet dated 11/3/09, indicated an order to administer the influenza vaccination. On 2/7/11, during the end of the day meeting with the facility staff, information was requested in regard to if the resident had received the influenza vaccine. On 2/9/11 at 8:15 a.m., the Director of Nursing Services (DNS) was queried in regard to if the resident had received her influenza vaccine. The DNS indicated on 2/7/11, the facility had done an audit on Resident #50's medical record and found the resident had not received her influenza vaccine.	F0334	**F 0334 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to ensure the administration of annual influenza vaccine as ordered and consented for each resident. Resident # 50 received the flu vaccine on 02/07/2011. Resident # 89 has been discharged from the facility. None of the identified residents experienced any negative outcome as a result of this finding. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will review all resident immunization records to ensure consents are present and vaccines are given and recorded on the immunization record. Any noted discrepancies will be clarified and corrected immediately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A nursing in-service will be conducted on 03/10/2011. This in-service will include review of the facility policy titled	03/13/2011

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	The Nurses Notes dated 2/7/11 at 1655 (4:55 p.m.) indicated a call was placed to the Power of Attorney (POA), who was unavailable, in regard to if the POA wanted the resident to have the influenza vaccine. On 2/7/11 at 2045 (8:45 p.m.) the POA returned the phone call and indicated the resident had not already received the vaccine and gave verbal approval to administer the influenza vaccine. 2. The closed clinical record of Resident # 89 was reviewed on 2/10/11 at 10:15 a.m., and indicated the resident had diagnoses which included, but were not limited to, hypertension and Alzheimer's disease. On the Influenza Immunization Record dated 9/16/10, indicated the residents responsible party had given permission to administer the influenza vaccine. On 2/11/11 at 9:00 a.m., an interview with the Infection Control Nurse indicated she had documented in a book that the resident had received her influenza vaccine; the book is not part of the resident's record. Resident # 89's Immunization Record was requested but not received prior to exit from the facility on 2/11/11.		"Influenza and Pneumococcal Immunization" **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DNS or designee will complete the CQI audit tool titled, "Infection Control" monthly x3 then quarterly thereafter to ensure ongoing compliance. Findings will be submitted to the CQI Committee for review and follow up. Compliance date: 03/13/2011	

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	3.1-13(a)			

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F0387 SS=D	Based on record review and interviews, the facility failed to ensure physician visits were every 30 days for the first 90 days and thereafter every 60 days, for 1 of 18 residents reviewed for physician visits in a sample of 18. (Resident #17) Findings include: The record of Resident #17 was reviewed on 02/07/11 at 1:00 p.m. Resident #17 was admitted to the facility on 05/20/10 with diagnoses including, but not limited to, CAD (Coronary Artery Disease), diabetes, CHF (Congestive Heart Failure), dementia, and depression. Review of "PHYSICIAN'S PROGRESS NOTES", since admission 05/2010, indicated the resident was seen on the following dates: 06/02/10 07/14/10 11/29/10 01/11/10 Interview with the Consultant RN for the corporation, on 02/10/11 at 9:00 a.m., indicated there was no further information in regard to a physician's visit. 3.1-22(d)(1)	F0387	**F 0387** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that the medical care of each resident is supervised by a physician and that each physician visit occurs timely per regulation. Residenti# 17's physician has been updatied regarding her currenti stiatiusResidenti# 17 did noti experience any negative outicome as a resulti of tihis fnding **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding. A facility audit of all records will be completed by the Nurse Management Team. This audit will ensure physician visits are timely and comply with state and federal regulations. Physicians will be notified promptly with any identified concerns. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A nursing in-service will be conducted on 03/10/2011. This in-service will review the facility policy titled, "Physician Visit	03/13/2011

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			Requirements Protocol". The nursing staff will be re-educated regarding required physician visits for new admissions and routine visits. Medical Records and/or other designee will be responsible for maintaining physician visit schedule. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Medical Records and/or designee will be responsible for completion of the CQI audit tool titled, "Physician Services". The audit tool will be completed weekly x4 weeks and then monthly thereafter to ensure ongoing compliance. Data will be submitted to the CQI Committee to review and follow up. Compliance Date: 03/13/2011	

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F0441	Based on observation, record reviews and interviews, the facility failed to follow the policy for mantoux tuberculin testing (Resident #33), and implement infection control procedures during bolus enteral feeding and dressing changes (Resident #80, #65), and not emptying a linen hamper (Resident #74). This deficient practice affected 3 of 18 residents reviewed for infection control in the sample of 18, and 1 of 2 residents in the supplemental sample. The facility also failed to properly sanitize shower chairs in the shower room on 1 of 3 units, potentially affecting the 37 residents who reside on the Heritage unit. Findings include: 1. The clinical record of Resident #33 was reviewed on 2/9/11 at 10:10 A,M, and indicated an admission date of 12/20/10. Documentation on the immunization sheet indicated a mantoux tuberculin skin test had been administered on 12/20/10. There was no documentation to indicate the result had been read nor that a second step mantoux tuberculin test had been done or that a mantoux tuberculin skin test had been done within the last year. Interview with the Consultant RN for the	F0441	**F 0441** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to maintain an Infection Control program that is designed to provide a safe, sanitary, comfortable environment and prevent the development of and transmission of disease and infection. Resident # 33 has been discharged from the facility. Resident # 80 continues with bolus feeding and did not experience any negative outcome as a result of this finding. Resident # 74 continues with treatment for contact dermatitis and linen hamper is emptied every shift by nursing staff. This resident experienced no negative outcome as a result of this finding. Resident # 65 continues with treatment to lower extremities. This resident experienced no negative outcome as a result of this finding. All shower chairs have been properly disinfected per facility policy. Any identified staff members will be thoroughly in-serviced/re-educated on proper technique in regards to Mantoux documentation, administration of	03/13/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	corporation, on 02/10/11 at 9:00 a.m., indicated there was no further information in regard to the documentation of the mantoux tuberculin test. 2. On 2/8/11 at 10:50 A.M., nurse #20 was observed to remove the piston (the part inside the syringe) from the syringe prior to administering a bolus G (gastric) tube feeding to Resident #80. She placed the piston on the blanket which was on top of the resident's bed. When the bolus feeding was finished, nurse #20 placed the piston back inside the syringe and placed both in a plastic container, ready for the next bolus feeding. During interview, on 2/11/11 at 1:50 P.M., the DNS indicated the syringe piston should have been placed on a towel and not on the blanket. 3. On 2/8/11 at 2:00 P.M., on the Heritage unit, CNA #22 was queried in regard to the procedure to sanitize the shower chairs. The CNA indicated she would spray the shower chair and leave the solution for 15 minutes. She was unsure of the name of the solution. Two procedures for sanitizing shower chairs were posted on the wall in the Heritage unit soiled utility room. One of		enteral feedings, disinfecting of resident care equipment/supplies, hand washing, glove use and handling of linen. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all nursing staff in-service will be conducted on 3/10/2011. This in-service will include review of facility Infection Control practices including a specific emphasis on: Tuberculin Skin Testing administration and documentation. Administration of enteral feedings using proper infection control technique. Facility protocol regarding disinfectant of shower chairs. Facility protocol regarding safe handling and disposal of soiled linen in hampers. Proper hand washing and gloving practices during routine resident care and dressing changes. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**	

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	the procedures, undated, was to spray the shower chair with TB quat and leave for 10 minutes. The second procedure, undated, was to spray the solution and leave on for 3 minutes. The solution was not named. On 2/9/11 at 8:40 A.M., the infection control nurse indicated the policy currently in use was to leave the solution on for 3 minutes and the solution being used was TB quat. 4. The clinical record of Resident #74 was reviewed on 2/9/11 at 1:40 P.M., and indicated the resident was being treated for contact dermatitis and that all her bed linens, towels, washcloths and incontinence pads were washed separately with a different detergent. On 2/8/11 at 3:40 P.M., during incontinence care for resident #74, the linen hamper, adjacent to the bed, specifically for resident #74, was observed to be full to overflowing. At this time, CNA #21 said she thought housekeeping staff was supposed to empty the linen hamper; however, the nurse indicated the CNAs were supposed to empty the linen hamper and remove the soiled linen.		The Charge Nurses and Nurse Management Team will monitor for proper infection control practices and procedures by making routine and random walking rounds observing for compliance. In addition, all nurses will be required to do a check-off/return demonstration on administration of enteral feedings as well as a dressing change to ensure ongoing compliance with this corrective action. Any observed concerns noted during check-offs will be addressed and corrected immediately. DNS and/or designee is responsible for completion of the CQI audit tool titled, “Resident Care Rounds” will be completed weekly x4 weeks, then monthly x3 months, and then quarterly thereafter to ensure ongoing compliance. The CQI audit tool titled, “Infection Control Review”, will be completed weekly x4 weeks then monthly thereafter to ensure ongoing compliance. Data from this audit will be submitted to the CQI committee for review and follow up. Compliance Date: 03/13/2011	

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F0441	5. The clinical record for Resident #65 was reviewed on 02/08/11 at 1:30 p.m. Resident #65 was admitted to the facility on 02/19/10 with diagnoses including, but not limited to, aortic stenosis, anemia, chronic CHF (Congestive Heart Failure), diabetes, peripheral neuropathy, and PVD (Peripheral Vascular Disease: poor circulation/blood perfusion). Review of the record for Resident #65 indicated the resident had stasis ulcers (ulcers caused by poor circulation) to both lower extremities and had daily dressing changes. On 02/09/11, between 10:10 a.m. and 11:10 a.m., LPN #3 was observed to change the right and left lower extremity dressings. LPN #3 was assisted by the DNS (Director Nursing Services). The DNS was observed to wash her hands and put on clean gloves before removing both the right and the left lower extremity dressings. The DNS then removed her gloves and washed her hands before putting on clean gloves. The DNS was observed to move a notebook from the bedding to the over-bed table, rearrange dressing supplies on top of the over-bed table, and move the resident's slippers from one area of the bed to another. The DNS than lifted and placed Resident #65's right leg, with the exposed open area	F0441	**F 0441** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to maintain an Infection Control program that is designed to provide a safe, sanitary, comfortable environment and prevent the development of and transmission of disease and infection. Resident # 33 has been discharged from the facility. Resident # 80 continues with bolus feeding and did not experience any negative outcome as a result of this finding. Resident # 74 continues with treatment for contact dermatitis and linen hamper is emptied every shift by nursing staff. This resident experienced no negative outcome as a result of this finding. Resident # 65 continues with treatment to lower extremities. This resident experienced no negative outcome as a result of this finding. All shower chairs have been properly disinfected per facility policy. Any identified staff members will be thoroughly in-serviced/re-educated on proper technique in regards to Mantoux documentation, administration of	03/13/2011

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	located on the posterior (back) of the leg, directly onto the bedding. The DNS removed the glove from the right hand, opened the room door and exited with the left glove on. The DNS then returned to the room, removed the left glove and regloved with clean gloves. The DNS then cleansed the anterior (front) left lower leg area with NS (normal saline) and patted the area dry with a clean towel. The DNS proceeded to cleanse an area on the upper right ankle with NS and patted it dry with a clean towel. The DNS removed her gloves and regloved to measure the affected areas. The DNS again removed her gloves and put a glove on the right hand to measure the depth an open area with a Q-tip, removed the right glove and regloved. The DNS then picked up a dropped glove from the floor and placed it in a trash can with her gloved hands. The DNS again removed her gloves and regloved to assist LPN #3 by holding the lower extremities of Resident #65. Interview with the ADNS (Assistant Director Nursing Services), on 02/09/11 at 8:30 a.m. in regard to infection control, indicated staff should wash hands before and between gloving for resident care procedures. The Handwashing Policy, provided by the ADNS at the time, did not		enteral feedings, disinfecting of resident care equipment/supplies, hand washing, glove use and handling of linen. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all nursing staff in-service will be conducted on 3/10/2011. This in-service will include review of facility Infection Control practices including a specific emphasis on: Tuberculin Skin Testing administration and documentation. Administration of enteral feedings using proper infection control technique. Facility protocol regarding disinfectant of shower chairs. Facility protocol regarding safe handling and disposal of soiled linen in hampers. Proper hand washing and gloving practices during routine resident care and dressing changes. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**	

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	specify when direct care personnel were to wash their hands. 3.1-18(f) 3.1-18(l)		The Charge Nurses and Nurse Management Team will monitor for proper infection control practices and procedures by making routine and random walking rounds observing for compliance. In addition, all nurses will be required to do a check-off/return demonstration on administration of enteral feedings as well as a dressing change to ensure ongoing compliance with this corrective action. Any observed concerns noted during check-offs will be addressed and corrected immediately. DNS and/or designee is responsible for completion of the CQI audit tool titled, “Resident Care Rounds” will be completed weekly x4 weeks, then monthly x3 months, and then quarterly thereafter to ensure ongoing compliance. The CQI audit tool titled, “Infection Control Review”, will be completed weekly x4 weeks then monthly thereafter to ensure ongoing compliance. Data from this audit will be submitted to the CQI committee for review and follow up. Compliance Date: 03/13/2011	

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F0502 SS=D	Based on record review and interview, the facility failed to ensure the laboratory performed blood tests as ordered by the physician in regard to a PT/INR (prothrombin time/international ratio). This deficiency affected 1 of 4 residents reviewed for laboratory tests in a sample of 18. (Resident #42) Findings include: The clinical record of Resident t#42 was reviewed on 2/7/11 at 2:10 P.M., and indicated diagnoses which included but were not limited to dementia, CHF (congestive heart failure) and atrial fibrillation. There was a physician's order, dated 1/10/11, for a PT/INR level to be done on 1/17/11. There was no documentation to indicate the test had been done. When interviewed on 2/10/11 at 9:10 A.M., the DNS indicated, after investigation, the laboratory had not followed the order for the lab on 1/17/11, but had waited until 1/19/11. 3.1-49(a)	F0502	**F 0502** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to provide or obtain laboratory services to meet the needs of its residents and that the facility is responsible for the quality and timeliness of these services. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** Resident # 42's lab orders have been obtained as ordered. The Physician is aware of this resident's current status. The identified resident experienced no negative outcome as a result of this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All residents with orders for PT/INR's have the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team. This audit will review all residents with physician's orders for PT/INR's to ensure all labs have been obtained as ordered. Any identified discrepancies will be corrected and/or clarified when noted.	03/13/2011

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			A nursing staff in-service will be conducted on 3/10/2011. This in-service will include review of the facility policy titled, "Guidelines for Lab Tracking". The in-service will emphasis the importance of following physician orders regarding lab monitoring and timely notification and follow up with all lab results. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS or designee will be responsible for completion of the CQI audit tool titled, "Coumadin Therapy" weekly x4 weeks, then monthly x3 months, and then quarterly thereafter. In addition the facility will utilize the Coumadin Flow Record to monitor residents on Coumadin Therapy. Data will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	

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F0507 SS=D	Based on review of records and interview, the facility failed to ensure laboratory reports were filed in the clinical record. This deficiency affected 3 of 4 residents reviewed for laboratory results, in a sample of 18. (Residents #67, 42 and 74) Findings include: 1. The clinical record of Resident #67 was reviewed on 2/10/11 at 10:25 A.M., and indicated diagnoses which included but were not limited to CVA (cerebral vascular accident- stroke) and diabetes mellitus. There was an order for a lipid panel to be done yearly. There was no documentation in the clinical record to indicate this had been done. On 2/10/11 at 3:15 P.M., the DNS indicated the lipid panel had been done on 11/9/10, however, the report had not been received in the facility. 2. The clinical record of Resident #42 was reviewed on 2/7/11 at 2:10 P.M., and indicated diagnoses which included but were not limited to dementia, Atrial fibrillation and CHF (congestive heart failure). There was a physician's order for a Kepra	F0507	**F 0507** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to ensure that laboratory results are accessible and placed in the clinical record. Resident # 67, Resident # 42, and Resident # 74's clinical records have been reviewed and all ordered lab reports are accessible and filed in each resident's clinical record. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents with orders for lab work are at risk to be affected by this finding and will be identified through a facility audit. This audit will review all residents with physician orders for lab draws to ensure all labs have been obtained as ordered and are accessible and filed in each resident's clinical record. Any identified discrepancies will be corrected/ clarified when noted. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all nursing staff in-service will be conducted on 03/10/2011 to review the facility process for	03/13/2011

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	level blood test to be done on 1/7/11. There was no result of the Kepra level in the clinical record. On 2/11/11 at 9:30 A.M., the DNS provided a copy of the report of the kepra level blood test. The report was marked as faxed to the facility on 2/10/11 at 18:14 hours. 3. The clinical record of Resident #74 was reviewed on 2/9/11 at 1:40 P.M., and indicated diagnoses which included but were not limited to dementia. A physician's order, dated 11/8/10, was for a pre-albumin lab test to be done on the next laboratory day. Documentation indicated the test had been done on 11/10/10, however the results were not received in the facility until 2/9/11. A faxed copy was received in the facility on 2/9/11 at 16.53 hours. 3.1-49(f)(4)		obtaining, reporting, and filing lab reports. The Nurse Managers and/ or other designees will ensure all labs are filed in the clinical record after nursing has reported results to the physician. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DNS or designee will be responsible for completion of the CQI audit tool titled, "Labs/Diagnostics" weekly x4, then monthly x3, and then quarterly thereafter for ongoing compliance. Any identified trends will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	

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F0514 SS=D	Based on interviews and record reviews, the facility failed to assure documentation of physician notification was complete in regard to a positive tuberculin test result for 1 resident. This deficiency affected 1 of 1 resident in a sample of 18 who had a positive tuberculin test result (Resident # 45). Findings Include: The clinical record of Resident # 45 was reviewed on 2/8/11 at 1:30 p.m., and indicated the resident had diagnoses included but not limited to, depression and Alzheimer's disease. The Immunization Record was dated 11/19/10, the Mantoux test was read on 11/21/10, and indicated a positive test result of seventeen millimeters. The Radiology result for a chest radiological result dated 11/16/10, indicated there was no evidence of cardiopulmonary disease. Nurses Notes dated 11/21/10, indicated there was no documentation the physician was notified of the positive Tuberculin test result.	F0514	**F 0514** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider to ensure clinical records are complete and accurately documented. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** Resident # 45's clinical record has been updated to reflect a positive tuberculin test and physician and family notification. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All residents are at risk to be affected by this finding. All resident charts will be audited to ensure tuberculin test results have been properly recorded in the clinical record as well as the presence of the physician and family notification. An all nursing staff in-service will be conducted on 03/10/2011. This in-service will include review of the facility process for obtaining, reporting, recording, and filing tuberculin test results in the clinical record. The nurse mangers or other designee will	03/13/2011

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	On 2/9/11 at 8:15 a.m., the DNS (Director Nursing Services) was queried in regard to no documentation that the Physician was notified on 11/21/10, of the residents positive Tuberculin test. The DNS indicated the resident's physician was notified of the positive Tuberculin test on 11/21/10, and no new orders were received and the Nurse Practitioner was at the facility and was informed of the test result. On 2/9/11 at 8:40 a.m., the Infection Control Nurse was queried in regard to no documentation that the physician was notified on 11/21/10, of a positive Tuberculin test. The Infection Control Nurse indicated the previous Assistant Director Nursing Services(ADNS) had not documented on 11/21/10, in the resident's medical record that she had notified the physician, the resident's family and the Department of Health in regard to the positive Tuberculin test result. 3.1-50(a)(1) 3.1-50(a)(2)		ensure all tuberculin results are filed in the clinical record after physician and family notification. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DNS or designee will be responsible for completion of the CQI audit tool titled, “Resident Mantoux” monthly x3 months and then bi-annually thereafter to ensure ongoing compliance. Any findings will be submitted to the CQI Committee for review and follow up. Compliance Date: 03/13/2011	

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F0516	Based on observation and interview, the facility failed to safeguard clinical record information against unauthorized use in regard to availability of the keys. This deficiency affected 2 of 2 clinical record storage rooms. Findings include: 1. During the environment tour on 2/8/11 at 1:25 P.M., accompanied by the maintenance and housekeeping supervisors, the following was observed: The record room door was locked and there was no-one in the room. There were 12 clinical record metal file cabinets in the medical record/medical record office, and three of the cabinets were unlocked. When queried, at this time, the maintenance supervisor and the housekeeping supervisor both indicated they had a key for this room. The second medical record storage room was locked and records were in plastic bins with lids. The medical records staff person indicated human resources staff and the business office staff had keys for this room as some of the plastic bins contained employee and business records.	F0516	**F 0516** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** It is the practice of this provider that all clinical record information is safeguarded against loss, destruction, or unauthorized use. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** The identified storage room locks have been replaced and new keys have been distributed only to appropriate personnel. No other clinical record storage rooms were noted to be affected by this finding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An all staff in-service will be conducted on 03/10/2011. This in-service will include review of the facility practice regarding storage of clinical records and the regulation regarding authorized access to these clinical records. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put**	03/13/2011

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	3.1-50(d)		**into place?** Ongoing compliance with this corrective action will be monitored through completion of the CQI audit tool titled, “Facility, Environmental Review” weekly x4 then monthly thereafter. The Maintenance Director, Medical Records, and/or other designee will be responsible for completion. Compliance Date: 03/13/2011	